Never Events – Updated guidance on reporting surgical errors for Medicare inpatients

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During the last few years, there has been considerable focus on certain events identified as "serious, largely preventable and of concern to both the public and health care providers." These events have become more popularly known as "never events"—events that should never occur in a well-run healthcare facility with appropriate quality controls. In June of this year, Medicare released three national coverage determinations (NCDs) for the following surgical errors:

- Wrong surgical or other invasive procedure performed on a patient (NCD 140.6);
- Surgical or other invasive procedure performed on the wrong body part (NCD 140.7); and
- Surgical or other invasive procedure performed on the wrong patient (NCD 140.8).

Under the new NCDs, effective for services performed on and after January 15, 2009, CMS will not cover surgical or other invasive procedures performed in error, as described above. In addition, Medicare will also not cover hospitalizations and other procedures "related" to these non-covered services.

When reporting outpatient surgical errors and related services, CMS has directed hospitals to attach one of the following modifiers, as appropriate, to each HCPCS code identifying those services on the claim:

- Wrong body part—PA
- Wrong patient—PB
- Wrong surgery—PC

With respect to inpatient stays during which surgical errors occur, but other covered services are also performed, CMS has directed hospitals to submit two separate claims:

- One claim, billed with type of bill (TOB) 011X (not including 0110, as an option), to report the covered services not related to the non-covered surgical errors; and
- A separate claim, billed with TOB 0110 (which is a no pay claim), to report the procedures performed in error, as well as all services related to those procedures.

In addition, for discharges prior to October 1, 2009, CMS directed hospitals to report on the no pay claim (TOB 0110) in UB-04 FL 80 (or on the 837i, at Loop 2300) the appropriate two-digit code to identify the nature of the surgical error:

- Wrong surgery—MX
- Wrong body part—MY
- Wrong patient—MZ

In Medicare Claims Processing Manual Transmittal 1815, released on Friday, CMS has changed the reporting guidelines for inpatient surgical errors and related services reported on TOB 0110. For discharges on and after October 1, 2009, CMS is directing hospitals to report one of the following diagnosis codes, instead of the two-digit code in FL 80 (or Loop 2300):

- E876.5 – Performance of wrong operation (procedure) on correct patient
- E876.6 – Performance of operation (procedure) on patient not scheduled for surgery
- E876.7 – Performance of correct operation (procedure) on wrong side/body part

In particular, CMS cautions that these diagnosis codes should be reported in one of the UB-04 secondary diagnosis FLs (67A-H) (or in comparable locations on the 837i), not in the External

Cause of Injury (E-code) FLs on the UB-04 or 837i. Hospitals are encouraged to review their coding and billing procedures to assure that they are correctly reporting these non-covered services, depending on the dates of discharge.